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Family and community orientation in children's primary healthcare

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Abstract *This article seeks to identify the principle of family and community orientation in Family Health Units, relating to care for the health of children under the age of 10. It is a quantitative, assessment study of 344 family members and/or carers of children under the age of 10, served in the 53 Family Health units of the 3rd ('IIIrd') Health District of the city of João Pessoa, Brazil. The data were collected based on the Family Orientation and Community Orientation variables present in the children's version of the Primary Care Assessment Tool – Brasil. Analysis took the form of simple frequency distribution statistics. Average scores for the components analyzed were between 3.7 and 5.7, lower than the level of 6.6 which is determined for these attributes to be oriented to primary healthcare. There is a weak orientation of the attributes Family Orientation and Community Orientation in the primary care of the services evaluated, and this indicates a need for a full approach to the child, with macro- and micro-political conceptions by those planning and managing healthcare, to ensure that children get full and effective healthcare.*

Key words *Family, primary healthcare, Family Health, child*

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Introduction

Structuring of Primary Health Care began as from the 1978 International Conference on Primary Health Care at Alma-Ata, aiming to implement other care models that would meet the health needs of populations[1]. In Brazil, Primary Health Care was expanded[1,2] with the creation of the Unified Health System (*Sistema Único de Saúde,* or SUS) in 1988 – based on a foundation in the principles of universal and full healthcare, with equity for individuals, family and community at all levels of care.

In this perspective, Brazil's Family Health Program (*Programa Saúde da Família* – PSF), now called the Family Health Strategy (*Estratégia Saúde da Família* – ESF), emerged. It is considered a landmark in Brazilian health quality due to its proposal for reorganization of the practice of healthcare in the Primary Health Care system. As a care model centered on the family and on the multi-profession team with longitudinal accompaniment[1,2], it serves as a basis for improvement in the population's quality of life and care, with a highlight for the child, due to the permanent process of growth and development and the problems that occur in this phase of life[3].

In care for the child, the actions taken in primary healthcare within the Family Health Strategy are indispensable for prevention of illness and promotion of health, because they enable early detection of possible alterations, with timely intervention, thus reducing the risks of illness leading to death in infancy[4].

For this, what is necessary is universal, full, equitably distributed, continuous and solution-delivering care[3], guided by the principles of Family-Centered Care and on the belief that the child's emotional and developmental needs, and the well-being of the whole of the family, are more effectively achieved when the health services activate the family's capacity to meet the needs of the child, based on their involvement in the planning of care. Thus, the relationship between the family and the health professionals is a central element for arranging for the child to receive quality healthcare[5].

The focus on the family and the community constitutes a new paradigm for the SUS, and is of fundamental importance for the reorganization of the services and of the Family Health Strategy. This focus obligatorily involves a system of Health Supervision that gives priority to vigilance of the space/population/family/community where the illness occurs and no longer the classic approach focused on the individual[6].

Thus, when discussing the reorganization of the health services in Brazil, one emphasizes the importance of evaluating them with the aim of measuring of the quality of care for children's health in this scenario, which presupposes, as well as the bio-psychosocial aspects, the creation of links between the services of primary healthcare, the family and the community[7].

In this point of view, it is defined[8] that an effective Primary Care Service, of quality, is defined by the presence and scale of four essential attributes: the first contact, continuity (or longitudinality), fullness of types of care, and coordination; and three derivative attributes: family centralization, community orientation, and cultural competence.

The attribute referred to as family centralization involves considering the family as the subject of the attention. Community orientation presupposes recognition of family needs due to the physical, economic, social and cultural context in which the families live[9].

Family orientation takes place when: The reach of the fullness of the service provides a base for consideration of the individual within his or her environments; evaluation of the needs for full attention considers the family context and its exposure to threats to health; the challenge of coordination of the care comes up against limited family resources[8].

In relation to orientation to the community, it is highlighted[8] that the needs related to peoples' health take place in a social context; the perception of these needs frequently requires knowledge of the social reality. An understanding of the health characteristics in the community and of the resources available provides a more extensive means of evaluating the needs than an approach based only on interactions with the patients or their families.

These principles are in harmony with what is proposed in the Family Health Strategy, the aim of which is to achieve a rupture from the passive behavior of health teams and extend its actions to the whole of the community.

The child, in his/her family and community context, may be subject to worsening in state of health. This study focuses on the child that is vulnerable to the problems known as the illnesses that are prevalent in infancy, and which require care.

In relation to the supply of children's health services, actions taken in primary healthcare are essential for the activities of prevention and intervention, due to their having potential for pos-

sible early detection of alterations and reducing risks of illness and/or death[10]. Studies indicate that high rates of hospitalization, including hospitalization of children, due to conditions that are sensitive to basic healthcare, indicate primary healthcare that is inadequate in relation to the type of location, intensity and appropriateness of the care given[11-13].

Recognizing Primary Health Care as a scenario that has the potential for resolution of the majority of the population's health problems, we ask: Why do children continue to get ill and to need hospitalization for illnesses that could be resolved at the primary healthcare level? Have these healthcare services, specifically the Family Health Units, succeeded in resolving health problems when the family brings their ill child for treatment? Have the family and the community been included in the health actions of the Family Health Units?

This study aims to identify the principles of family orientation and community orientation in Family Health Units, in relation to healthcare for children under the age of 10, as a means to establishing and expressing our reflections on healthcare actions intended to serve the public of children in the Primary Healthcare services, and proposing changes based on them.

Methods

This is a quantitative-approach, assessment-oriented cross-sectional study carried out in the 53 Family Health Teams of Health District III (DS-III) of the municipality of João Pessoa (in the Brazilian state of Paraíba). This city has a population of 180,000, with 90.5% of the families in the area covered by the Family Health Strategy. This district was chosen due to its being the largest in the basic healthcare network of that city.

The population of the study comprised family members (father, mother) and/or carers (grandparents, aunts and uncles, legal guardians) of children up to the age of 9 years, 11 months, and 29 days, cared for in the Family Health Units, in a period of six months prior to the stage of collection of data for the survey, which took place between July and December 2011. The number of healthcare actions previously identified was 21,486, distributed between the teams, on the basis of which the sample was established – decided by stratified simple casual probabilistic sampling, with proportional sharing of the number of children attended by unit of the district – comprising 344 families and/or carers, adopting a sampling error of 5% and a confidence level of 95%.

The selection of the participants was by systematic sampling in the line of people waiting for a medical consultation or for nursing: The last family member and/or legal guardian of the child present in the queue of people waiting for care was invited, and if they did not accept, the immediately prior person, and thus, successively, until completion of the sample quota established for each unit. The interview was carried out within the units of the Family Health Strategy, in the waiting rooms, following the ethical recommendations for presentation of the study to the participant. In view of this, the family members and/or carers of children under the age of 10 resident in the urban area of the municipality of João Pessoa who presented conditions to be a respondent for the form, such as capacity of understanding, expression and comprehension of the documents presented, were selected. The participant was required to be familiar with the unit that he/she would evaluate, including the participant who took the child for care at that specific health unit at least two times prior to the visit in which he/she was awaiting attendance.

Data was collected using an instrument prepared and validated in Brazil, the PCA Tool–Brasil, children's version. This contains 45 questions for ascertaining the essential and derivative attributes of basic healthcare, including: family orientation – item 'I' of the instrument (containing three questions); and community orientation – item 'J' of the instrument (with four questions). The data on the social-demographic characteristics of the family were obtained through an instrument specifically prepared for this purpose.

It is emphasized that at the beginning of the PCATool instrument there are three questions that measure the degree of affiliation to the health service: The respondent may affiliate him or herself to the professional referred to as 'nurse', or 'doctor', or to the 'service' (the Family Health Unit itself), or indicate an 'other'. By opting for a professional or service, the respondent continued, for the rest of the interview, evaluating that professional or service referred to. The answers to the instrument were of the Likert type with specific++for tables++values: 'Yes certainly' (value = 4), 'yes probably' (value = 3), 'probably no' (value = 2), 'certainly no' (value = 1) and 'I don't know, I can't remember' (value = 9), with scores being calculated at the end.

The scores were calculated by the average of the values of the answers of the items that com-

prise each attribute or its component[14]. The average score for the attributes Family orientation and Community orientation were calculated by the sum of the value of the items divided by the number of items of each component, as established in the manual of the instrument PCATool–Brasil, published by the Brazilian Health Ministry[14]. Thus we have: Average score I = (I1 + I2 + I3)/3 and average score J = (J1 + J2 + J3 + J4) /4. The scores obtained for each component were transformed into a scale from 0 to 10, being named the adjusted score, by the formula:

Adjusted score = (score obtained – 1) x 10/3

Scores of 6.6 or over were considered high or satisfactory, and scores less than 6.6 were considered to be low or unsatisfactory, demonstrating that the attribute is or is not offered appropriately by the services being researched. The data were inserted in a spreadsheet of Microsoft Excel 2010 to form a database and analyzed quantitatively tabulated in the form of simple distribution statistics of absolute and relative frequencies.

The survey was carried out obeying the ethical precepts of Resolution 466/12, under the approval of the Research Ethics Committee of the University of the West of Paraná (*Universidade do Oeste do Paraná* – UNIOESTE).

Results

Table 1 presents the social-demographic characteristics of the 344 family members and/or carers of children attended in the Family Health units of Health District III of João Pessoa. A highlight of this population is their low socio-economic condition, with family income of up to one times the minimum wage in 58.4% of the families; however, half of the sample presented more than 10 years' schooling. As to family size, 45.4% of the sample had only one child and 33.4% of the families had two children. Of those interviewed, 80% of the parents were married or had a stable union, and 43.9% of the children's mothers had occupation classified as Homemaker.

Table 2 shows the components related to the attribute Family orientation, present in the instrument of the PCATool, with the absolute values and the percentages relating to the respective answers. When the participants of the study were questioned on the attitude of the professionals of Basic Healthcare – whether they asked them their opinions on the treatment and care of the children – 33.7% of mothers answered that they were certain that the nurses did not ask questions on this aspect, and 24.1% stated that the doctors did not question them. As to the professional that best knew the family's health problems, 41% of the carers interviewed referred to nurses, and 20.8% referred to the doctor. Also, 21.8% of the interviewees believed that the nurse would meet with their family, if it were necessary.

Table 1. Social-demographic characteristics of the family and of the children's carer, João Pessoa (State of Paraíba), Brazil, 2013.

Variables	n = 334	
	N	%
What is the household's approximate total income?		
Less than one minimum wage	42	12.36%
Equal to the minimum wage	159	677.2%
Twice the minimum wage	91	721.4%
Three times the minimum wage	31	9.83%
Four times the minimum wage	9	99.6%
More than four times the minimum wage	10	829.9%
No income	-	–
Don't know	2	99.6%
How many years' schooling does the principal carer have?		
0–4	39	11.3%
5–9	114	33.1%
10–14	174	50.6%
15 or more	16	4.7%
Don't know	1	0.3%
How many children in the family?		
One	156	45.4%
Two	115	33.4%
Three	44	12.8%
Four	16	4.7%
Five	8	2.3%
More than five	5	1.5%
Don't know / did not say	-	–
What is the marital situation of the child's parents?		
Married	108	31.4%
Stable union	167	48.6%
Single	50	14.5%
Widow or widower	4	1.2%
Don't know	15	4.4%
What is the mother's occupation?		
Formal employment	52	15.1%
Self– / informally employed	30	8.7%
Farm / rural worker	1	0.3%
Not in work	72	20.9%
Housewife	151	43.9%
Other	38	11.0%

Table 2. Absolute and percentage frequency for the attribute Family orientation, João Pessoa, Paraíba State, Brazil, 2013.

Indicator	n = 334									
	No, certainly		No, probably		Yes, probably		Yes, certainly		Don't know/ remember	
	n	%	n	%	n	%	n	%	n	%
I1 - Professional asks the family about treatment of the child										
Nurse	116	33.7	6	1.7	16	4.7	65	18.9	2	0.6
Doctor	83	24.1	1	0.3	2	0.6	26	7.5	1	0.3
Family Health Unit	18	5.2	1	0.3	-	–	-	–	-	–
Other*	5	1.5	-	–	1	0.3	1	0.3	-	–
Total	222	64.5	8	2.3	19	5.6	92	26.7	3	0.9
I2 - The professional is aware of the family's health problems										
Nurse	49	14.2	3	0.9	7	2	141	41	5	1.5
Doctor	35	10.2	5	1.5	1	0.3	72	20.8	-	–
Family Health Unit	6	1.7	-	–	-	0	13	3.8	-	–
Other*	3	0.9	-	–	1	0.3	3	0.9	-	–
Total	93	27	8	2.4	9	2.6	229	66.5	5	1.5
I3 - The professional would meet the family when necessary										
Nurse	23	6.7	21	6.1	68	19.8	75	21.8	18	5.2
Doctor	22	6.4	15	4.3	26	7.5	25	7.3	25	7.3
Family Health Unit	3	0.9	5	1.4	3	0.9	3	0.9	5	1.4
Other*	2	0.6	1	0.3	3	0.9	1	0.3	-	–
Total	50	14.6	42	12.1	100	29.1	104	30.3	48	13.9

* Other: hospital.

According to the data of Table 3, in relation to the attribute Community orientation, 46.6% of the interviewees responded that they were certain that the nurse usually carries out home visits and 22.9% stated that the doctor makes the visit. In relation to the professionals' knowledge and awareness on the health problems that are important in the neighborhood, 16.9% of the interviewees were certain that the nurses are aware of them, and 9.6% were certain that the doctors were aware of them. In relation to the identification of problems through surveys/research in the community, 23.8% of the interviewees did not remember whether the nurse carries out these surveys and 13.4% said they did not remember the doctor carrying them out. Of the carers interviewed, 16.6% reported that they were certain that the nurse invites the members of the family to take part in the Local Health Council.

In relation to the average scores of the attributes researched, according to the data of Table 4, the score for family orientation was 3.7, that is to say, an amount that is considered low (less than 6.6), and the score for community orientation, at 5.7, was also below the level considered to be good.

Discussion

The use of an instrument that has been validated for assessing health services is of the maximum importance, because, based on the attributes of the Basic Healthcare, it makes it possible to ascertain the perception of users as to the services provided to the population, and in the case of the present study, to children below the age of 10[9].

The scores on the attributes Family orientation and Community orientation in relation to care for the children that are users of the Family Health Units surveyed were considered to be unsatisfactory for the effective healthcare. These results are a source of concern, since these attributes represent fundamental elements for the strengthening of the link between the health service, families and community, considering the family as the central pivot of care for the child, and the Family Health Strategy as the currently effective model.

Table 3. Absolute and percentage frequency for the attribute Community orientation, João Pessoa, Paraíba State, Brazil, 2013.

Indicator	n = 334									
	No, certainly		No, probably		Yes, probably		Yes, certainly		Don't know/ remember	
	n	%	n	%	n	%	n	%	n	%
JI - Someone from your service makes household visits										
Nurse	18	5.2	6	1.7	6	1.7	160	46.6	15	4.4
Doctor	19	5.5	2	0.6	5	1.5	79	22.9	8	2.3
Family Health Unit	4	1.2	-	-	2	0.6	13	3.7	-	-
Other*	4	1.2	-	-	1	0.3	2		-	-
Total	45	13.1	8	2.3	14	4.1	254	73.8	23	6.7
J2 - Your service is aware of the neighborhood's health problems										
Nurse	27	7.8	23	6.7	51	14.8	58	16.9	46	13.4
Doctor	24	7	13	3.7	15	4.4	33	9.6	28	8.1
Family Health Unit	2	0.6	4	1.1	3	0.9	7	2	3	0.9
Other*	3	0.9	1	0.3	2	0.6	-	-	1	0.3
Total	56	16.3	41	11.8	71	20.7	98	28.5	78	22.7
J3 - Your service carries out research in the community to identify problems										
Nurse	28	8.1	16	4.7	28	8.2	51	14.8	82	23.8
Doctor	28	8.1	4	1.2	7	2	28	8.1	46	13.4
Family Health Unit	9	2.5	3	0.9	1	0.3	4	1.2	2	0.6
Other*	3	0.9	1	0.3	1	0.3	1	0.3	1	0.3
Total	68	19.6	24	7.1	37	10.8	84	24.4	131	38.1
J4 - Does your service invite members of the family to participate in the Local Health Council?										
Nurse	62	18	23	6.7	10	2.9	57	16.6	53	15.4
Doctor	45	13.1	11	3.2	9	2.6	22	6.3	26	7.6
Family Health Unit	13	3.7	1	0.3	1	0.3	3	0.9	1	0.3
Other*	6	1.8	-	-	1	0.3	-	-	-	-
Total	126	36.7	35	0.2	21	6.1	82	23.8	80	23.3

* Other: hospital.

A study[9] on carers of children resident and registered in the areas covered by the family health units of the city of Montes Claros (Minas Gerais, Brazil) also found that the score for the attribute Family orientation did not present a satisfactory value in any of the services assessed.

The users interviewed in the Family Health Units of João Pessoa (Paraiba) have a predominant profile of low income, married, mother whose work activity is classified as Homemaker and principal carer, with more than 10 years' schooling. The literature[15-17] highlights that the majority of children's carers served in a health unit have low schooling, which contributes to bad eating habits and care habits in general, and may adversely affect the child's health. In counterpart, a study[9] highlights that the mother having more than eight years' schooling may possibly not show better scores attributed to the Family Health Strategy, since, the more schooling the individual has, the greater critical sense that individual will have and the greater probability of not using only this service as a regular source of healthcare.

After analysis of the questions used in the evaluation of the attribute Family orientation, it is seen that few mothers stated that the health professionals of Basic Healthcare do not usually find out their opinion as to the children's health. However, it is the nurses that have a higher prob-

Table 4. Statistical measures of scores, simply and from 0 to 10, in relation to Family orientation and Community orientation, João Pessoa (PB), Brazil, 2013.

Statistical	Simple score	Score, 0-10
Family orientation		
Average $\bar{x}$	2.1	3.7
Standard error	0.06	0.1
Median	2.0	3.3
Mode	1.0	-
Community orientation		
Average $\bar{x}$	2.7	5.7
Standard error	0.06	0.1
Median	2.7	5.8
Mode	4.0	10.0

ability of strengthening the family's bond of confidence in the service, because they maintain a greater contact with the population, and thus it is they that better know the family and its social context, its difficulties and limitations, and seek to monitor the children in basic healthcare, as specified by the Health Ministry.

This attribute is inter-related with the integral nature of the care provided: i.e. the requirement that the relations established in the family context and the factors that expose the user to conditions that are adverse or favorable to the process of health are taken into account in the practice of health[18].

This aspect is strengthened in a study whose authors[19] state that child health calls for change, in the sense of a need to avoid health workers being indifferent to the needs of individuals, the low capacity for providing real solutions, and deterioration of the quality of the service provided – and for the user to be seen in his or her intra- and extra-family environment, articulating the attention to the user with the focus on the family[20].

To determine whether the medical care for the child in primary care with family orientation was associated with the quality and equity of the care, this study found that, compared to the children who did not receive care based on this focus, the quality of care was significantly better evaluated, and grew from 41.7% to 52.0% over the period of evaluation. The accompaniment of the development time was also better. The authors emphasized the importance and the benefits of the model of care for the child with a family focus, accentuating the reduction of the disparities when this focus guides the care[21].

It is important that the doctor and the nurse should involve themselves with the family, for the bond to be formed. This will cause them to acquire a wide vision of the family's problems, needs and priorities, facilitating development of an adequate plan of care for the child and his/her family members[5]. This is because the bond established between the professional and the family makes the actions of care become efficacious, because they contribute to the autonomy of the family and the continuity of the care for the child and in its seeking out the health services[22].

Another important aspect in the results relates to the attribute of Community orientation, in relation to the questioning of professionals about the community's health problems. If we add up the results considered negative ('Certainly, no', and 'I don't know/don't remember' ++check response table), 57% of the mothers/carers believe that these professionals do not seek to identify the community's health problems.

To analyze the performance in compliance with the attributes of Primary Health Care, a study that carried out an evaluation with users, professionals, coordinators and managers of the health service found a significant departure from the principle of fullness of care, and that the users' perception of health was significantly associated with positive evaluation of the provision of health services and of their public nature. However, it identified low qualification of family focus, and community orientation[23].

One study[24] comments that the insertion of health professionals in the community, through surveys in the community itself, not only strengthens bonds, but also results in people understanding the social determinants of the health/illness process. This is because contact by health professionals with the population provides a space for each individual to be accepted and heard in his own singularity, which helps to restore the autonomy of the person who seeks healthcare and, consequently, dissemination of knowledge. Also, the results show that a small percentage of mothers state that the professionals orient the community to participate in the Local Health Council, which tends not to encourage participation of the population in the decisions and in mechanisms of social participation. The participation of the community, with representation of the users of basic healthcare services in health councils, has been limited[20], perhaps due to lack of encouragement by health professionals,

or because they never orient the population on this aspect.

This result shows the need for a review of the process of work of Family Health teams, to provide conditions for the population to have participation in the formulation of proposals and interventions, both in the primary healthcare service and in the decisions of the Health Council[20], for the decisions on government activity together with the community to be realized in areas of the population's interests, needs and knowledge.

Conclusion

This study is important due to the fact that the evaluation method provides knowledge of the reality lived by the professionals and users of the health services, with possibilities of laying out strategies for their improvement, with a view to promotion of children's health.

The data reveal that the attributes Family orientation and Community orientation within the activity of Primary Healthcare are not yet being offered in an appropriate way by the Family Health Strategy. Thus, it becomes necessary to expand the degree of attention given to the child, with macro- and micro-political conceptions on the part of the people planning and managing healthcare, so as to effect real interdisciplinary action to ensure that children's healthcare is indeed full and effective. To improve the supply of the attributes surveyed, Primary Healthcare should consider the family as a subject of care, it should have full knowledge of its health needs, and it should meet them in a singular manner. It should also recognize the resources available in the community for promotion of the child's health and well-being.

This point of view is directly related to the quality of the care provided to the child population, considering that the child's health depends on the family and on the community to be effective in fact. One can infer that quality Primary Healthcare is an effective strategy in the quest for promotion of health, prevention of illnesses, better state of health for children and greater satisfaction of the family and the community.

Finally, it is believed that the results of this study could help Family orientation and Community orientation in the primary healthcare provided to become the focus of attention for professionals and managers in care practice, providing what the population has a right to: Enjoyment of quality healthcare in the SUS.

Collaborations

APS Reichert and ABA Leôncio took part in: the conception, planning, analysis and interpretation of the data; writing of the article and significant critical review of the intellectual content; and final approval of the version to be published. BRG Toso and N Collet took part in: the conception, and writing of the article; significant critical review of the intellectual content; and final approval of the version to be published. NCC Brito and EMC Vaz participated in: the writing of the article; significant critical review of the intellectual content; and final approval of the version to be published.

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